FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023952

Facility Name: Apostolic Christian Restmor

Address: 935 East Jefferson Street (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: 309-266-7141 **Fax #** 309-266-7877

IDPA ID Number:

Date of Initial License for Current Owners: April 1978

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501-c-3

In the event there are further questions about this report, please contact:
Name: Michael Kaiser **Telephone Number:** 309-266-7141

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2005 to 12-31-2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	26	Sheltered Care (SC)	26	9,490	5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,515	21,666	3,665	32,846	8
9	SNF/PED					9
10	ICF		5,115		5,115	10
11	ICF/DD					11
12	SC		5,666		5,666	12
13	DD 16 OR LESS					13
14	TOTALS	7,515	32,447	3,665	43,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.87%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on wheels, pharmacy

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/1978

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,665

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,706	24,691	143,058	450,455		450,455		450,455			1
2	Food Purchase		279,001		279,001	(6,312)	272,689	(12,015)	260,674			2
3	Housekeeping	129,844	35,075	6,880	171,799		171,799		171,799			3
4	Laundry	80,263	17,878		98,141		98,141		98,141			4
5	Heat and Other Utilities			142,670	142,670		142,670		142,670			5
6	Maintenance	121,802	11,458	132,481	265,741	(661)	265,080	(3,830)	261,250			6
7	Other (specify):*			19,408	19,408		19,408		19,408			7
8	**TOTAL General Services**	614,615	368,103	444,497	1,427,215	(6,973)	1,420,242	(15,845)	1,404,397			8
	B. Health Care and Programs											
9	Medical Director			6,150	6,150		6,150		6,150			9
10	Nursing and Medical Records	2,629,452	161,796	23,915	2,815,163	(41,369)	2,773,794		2,773,794			10
10a	Therapy			196,826	196,826		196,826		196,826			10a
11	Activities	132,319	6,936		139,255		139,255	(805)	138,450			11
12	Social Services	146,408	597		147,005		147,005		147,005			12
13	CNA Training					6,254	6,254		6,254			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,908,179	169,329	226,891	3,304,399	(35,115)	3,269,284	(805)	3,268,479			16
	C. General Administration											
17	Administrative	175,482			175,482		175,482	(27,600)	147,882			17
18	Directors Fees											18
19	Professional Services			48,211	48,211	(1,443)	46,768	(9,639)	37,129			19
20	Dues, Fees, Subscriptions & Promotions			38,905	38,905	(1,184)	37,721	(17,541)	20,180			20
21	Clerical & General Office Expenses	200,467	33,274	56,611	290,352	(16,050)	274,302	(24,113)	250,189			21
22	Employee Benefits & Payroll Taxes			1,071,210	1,071,210	7,496	1,078,706	(6,312)	1,072,394			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,699	25,699	(1,757)	23,942	(9,066)	14,876			24
25	Other Admin. Staff Transportation			6,902	6,902	(109)	6,793	(3,877)	2,916			25
26	Insurance-Prop.Liab.Malpractice			129,678	129,678		129,678		129,678			26
27	Other (specify):*											27
28	**TOTAL General Administration**	375,949	33,274	1,377,216	1,786,439	(13,047)	1,773,392	(98,148)	1,675,244			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,898,743	570,706	2,048,604	6,518,053	(55,135)	6,462,918	(114,798)	6,348,120			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Restmor #0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			151,353	151,353		151,353	(18,074)	133,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					29,544	29,544		29,544			35
36	Other (specify):*											36
37	**TOTAL Ownership**			151,353	151,353	29,544	180,897	(18,074)	162,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	267,056	1,613,950	246,363	2,127,369	25,591	2,152,960	(1,212,501)	940,459			39
40	Barber and Beauty Shops	26,397		3,125	29,522		29,522		29,522			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	293,453	1,613,950	315,188	2,222,591	25,591	2,248,182	(1,212,501)	1,035,681			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,192,196	2,184,656	2,515,145	8,891,997		8,891,997	(1,345,373)	7,546,624			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Apostolic Christian Restmor

ID# **0023952**

Report Period Beginning: **1-1-2005**

Ending: **12-31-2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust out items for setup to deferred maint	$ (4,527)	6	1
2	Adjust in deferred main from schedule	4,751	6	2
3	Adjust out maint items missed for capitalization	(4,054)	6	3
4	Non allowable seminar	(3,064)	24	4
5	Non allowable dues and subscriptions	(6,043)	20	5
6	Outside pharmacy	(1,212,501)	39	6
7	Non allowable promotion	(11,438)	20	7
8	Employee meal income	(6,312)	22	8
9	Guest Meal income	(872)	2	9
10	Telephone income	(546)	21	10
11	Misc income	(22,249)	21	11
12	Misc expense	(1,318)	21	12
13	Administrative auto expemse	(3,877)	25	13
14	Non straightline depr	(18,074)	30	14
15	Medicare billing costs	(6,731)	19	15
16	Meals on wheels cost	(10,200)	2	16
17	Act sales	(805)	11	17
18	Parkside Management Fee	(27,600)	17	18
19	Out of state travel	(6,002)	24	19
20	Employee meal income	(943)	2	20
21	Penalties	(60)	20	21
22	Non care legal	(2,908)	19	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,345,373)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,015)	0	0	0	0	0	0	0	0	0	0	(12,015)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,830)	0	0	0	0	0	0	0	0	0	0	(3,830)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,845)	0	0	0	0	0	0	0	0	0	0	(15,845)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(805)	0	0	0	0	0	0	0	0	0	0	(805)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(805)	0	0	0	0	0	0	0	0	0	0	(805)	16
	C. General Administration													
17	Administrative	(27,600)	0	0	0	0	0	0	0	0	0	0	(27,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,639)	0	0	0	0	0	0	0	0	0	0	(9,639)	19
20	Fees, Subscriptions & Promotions	(17,541)	0	0	0	0	0	0	0	0	0	0	(17,541)	20
21	Clerical & General Office Expenses	(24,113)	0	0	0	0	0	0	0	0	0	0	(24,113)	21
22	Employee Benefits & Payroll Taxes	(6,312)	0	0	0	0	0	0	0	0	0	0	(6,312)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,066)	0	0	0	0	0	0	0	0	0	0	(9,066)	24
25	Other Admin. Staff Transportation	(3,877)	0	0	0	0	0	0	0	0	0	0	(3,877)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(98,148)	0	0	0	0	0	0	0	0	0	0	(98,148)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,798)	0	0	0	0	0	0	0	0	0	0	(114,798)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(18,074)	0	0	0	0	0	0	0	0	0	0	(18,074)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,074)	0	0	0	0	0	0	0	0	0	0	(18,074)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,212,501)	0	0	0	0	0	0	0	0	0	0	(1,212,501)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,212,501)	0	0	0	0	0	0	0	0	0	0	(1,212,501)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,345,373)	0	0	0	0	0	0	0	0	0	0	(1,345,373)	45

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bruce Sauder, Director	0			The Parkside of Morton		Congregate Linving
Steve Roeschley, Director	0					
Ed Kaiser, Director	0					
John Zimmerman, Director	0					
Howard Getz, Director	0					
James Ritthaler, Director	0					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 2-31-2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1				NONE			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0023952

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1978	$ 125,000	1
2	Cong Living	45 acres	1991-2005	582,371	2
3	TOTALS	#VALUE!		$ 707,371	3

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1978	1961	$ 315,426	$ 5,626	25	$	$ (5,626)	$ 315,426	4
5				1962	59,373		25			59,373	5
6				1965	324,445		25			324,445	6
7				1971	2,813		20			2,813	7
8				1976	112,250		20			112,250	8
	Improvement Type**										
9				1978	15,000		20			15,000	9
10				1979	7,888		20			7,888	10
11				1980	50,819		16			50,819	11
12				1981	90,107		16			90,107	12
13				1982	96,603		18			96,603	13
14				1983	39,124		16			39,124	14
15				1984	243,503		16			243,503	15
16				1986	660,199	33,010	20	16,504	(16,506)	660,199	16
17				1986	18,532		18			18,532	17
18				1987	122,666	3,182	20	6,133	2,951	119,594	18
19				1987	27,395		20	1,370	1,370	26,715	19
20				1988	85,020		15			85,020	20
21				1989	46,665		15			46,665	21
22				1990	7,131		8--20	81	81	6,763	22
23				1991	38,812		10--15			38,812	23
24				1992	55,156		5--10			55,156	24
25				1993	46,959	1,748	10		(1,748)	46,959	25
26				1994	3,462		10			3,462	26
27				1995	64,958	4,141	10--15	4,163	22	45,195	27
28	Locking System			1996	12,447	830	15	830		8,299	28
29	Roof Repairs			1996	2,500		5			2,500	29
30	Water Heater			1996	7,066	705	10	705		7,066	30
31	Sink			1996	3,148	210	15	210		2,099	31
32	Carpet			1996	1,824	182	10	182		1,807	32
33	Quick Channels			1996	585	58	10	58		577	33
34	Oxygen Control Manager			1996	5,301	442	12	442		4,345	34
35	Room Closets			1996	44,000	2,200	20	2,200		21,267	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ventilator Remodeling	1996	$ 34,281	$ 2,285	15	$ 2,285	$	$ 22,090	37
38	Carpeting	1996	20,762	2,076	10	2,076		19,896	38
39	Sewer Repair	1996	5,534	369	15	369		3,474	39
40	Roofing Repair	1996	2,950		5			2,950	40
41	Wallpaper Drapes	1996	5,409	361	15	361		3,398	41
42	Dining Room Door	1997	1,658	111	15	111		979	42
43	Electric Installed for A/C	1997	2,300	115	20	115		997	43
44	Floor Covering Therapy	1997	656	66	10	66		554	44
45	Fire Alarm System	1998	15,800	1,317	12	1,317		10,535	45
46	Conference Room carpet	1998	1,112	111	10	111		852	46
47	Shower Repairs	1998	1,524	102	15	102		772	47
48	A/C Compressor	1998	6,485	811	8	811		6,149	48
49	Pharmacy Building Improvements	1998	2,503	167	15	167		1,183	49
50	Broom Closet	1998	700	47	15	47		332	50
51	Ceiling Tile	1999	1,600	160	10	160		1,120	51
52	Pharmacy Building Improvements	1999	8,585	572	15	572		3,957	52
53	Door Alarm	1999	6,075	868	7	868		6,003	53
54	Bulletin Boards	1999	5,669	567	10	567		3,874	54
55	Wallcovering Room 117	1999	889	89	10	89		601	55
56	Nursing Office	1999	4,401	440	10	440		2,897	56
57	Computer Cables	1999	11,475	1,639	7	1,639		10,517	57
58	Blinds	1999	605	61	10	61		386	58
59	Break Room Carpet	1999	1,515	216	7	216		1,351	59
60	Marketing Office Electric	1999	2,768	185	15	185		1,233	60
61	Thin Trees	1999	1,765		5			1,765	61
62	Mulch	1999	1,300		3			1,300	62
63	Exhange Oil Tanks	1999	15,833		15	1,056	1,056	6,951	63
64	Roof Repair	2000	4,365		2			4,365	64
65	Dining Room Floor	2000	2,788	139	4		(139)	2,788	65
66	Vestibule Alarm	2000	4,618		4			4,618	66
67	Bathroom Floor Covering	2000	1,229		4			1,229	67
68	Air Duct for Telephone	2000	3,160		4			3,160	68
69	Med Room A/C	2000	5,483	91	5	90	(1)	5,483	69
70	TOTAL (lines 4 thru 69)		$ 2,796,974	$ 65,299		$ 46,759	$ (18,540)	$ 2,696,142	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,796,974	$ 65,299		$ 46,759	$ (18,540)	$ 2,696,142	1
2	Dining Room Compressor	2000	4,348	72	5	71	(1)	4,348	2
3	Trees	2001	3,500		20	175	175	729	3
4	New Sidewalk	2001	2,920		10	292	292	1,217	4
5	Sealcoating	2003	4,130	1,205	2	1,205		4,130	5
6	Corridor Doors	2005	3,510	98	15	98		98	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,815,382	$ 66,674		$ 48,600	$ (18,074)	$ 2,706,664	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,537,209	$ 77,758	$ 77,758	$	2--15	$ 1,318,853	71
72	Current Year Purchases	78,464	5,675	5,675		5--12	5,675	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,615,673	$ 83,433	$ 83,433	$		$ 1,324,528	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Bus, 1996 dodge van	1990, 1996	$ 60,654	$	$	$		$ 60,654	76
77	Pharmacy Transportaion	1992 van	1999	7,459					7,459	77
78	Staff & Administration	1998 century, wagon	1998	44,940					44,940	78
79	Facility Operation	Machinery & Equipment		14,719	1,246	1,246			8,721	79
80	TOTALS			$ 127,772	$ 1,246	$ 1,246	$		$ 121,774	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,266,198	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,353	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 133,279	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,074)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,152,966	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 29,544 Description: Copiers,17493, vents,11390, Storage, 661
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		1,800		1,800
5	In-House Trainer Wages	(c)		4,154		4,154
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests			300		300
9	TOTALS		$	$ 6,254	$	$ 6,254
10	SUM OF line 9, col. 1 and 2	(e)	$ 6,254			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 74,932	$		$ 74,932	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			21,695			21,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			100,199			100,199	4
5	Physician Care	39	visits			550			550	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	267,056		1,823,794			2,090,850	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39		23,725					23,725	12
13	Other (specify): Lab	39				37,835			37,835	13
14	TOTAL			$ 290,781		$ 2,059,005	$		$ 2,349,786	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 461,596	$	1
2	Cash-Patient Deposits	6,982		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	827,928		3
4	Supply Inventory (priced at)	187,709		4
5	Short-Term Investments	5,891,413		5
6	Prepaid Insurance	135,502		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	28,172		8
9	Other(specify):	59,632		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,598,934	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,552,122		13
14	Buildings, at Historical Cost	3,064,951		14
15	Leasehold Improvements, at Historical Cost	992,989		15
16	Equipment, at Historical Cost	1,743,444		16
17	Accumulated Depreciation (book methods)	(4,662,903)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,690,603	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,289,537	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 279,217	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,982		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,010		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,012		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		211,810		36
37		339,200		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,006,231	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,006,231	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,283,306	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,289,537	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1-1-2005 **Ending:** 12-31-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,277,657	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,277,657	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,005,649	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,005,649	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,283,306	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,656,540	1
2	Discounts and Allowances for all Levels	(512,142)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,144,398	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,482	6
7	Oxygen	8,809	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 319,291	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	38,195	13
14	Non-Patient Meals	25,744	14
15	Telephone, Television and Radio	546	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,982,131	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,460	19
20	Radiology and X-Ray		20
21	Other Medical Services	225,485	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,317,561	23
	D. Non-Operating Revenue		
24	Contributions	506,472	24
25	Interest and Other Investment Income***	160,872	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 667,344	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	55,543	28
28a	Restructuring Cancelled	1,393,509	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,449,052	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,897,646	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,427,215	31
32	Health Care	3,304,399	32
33	General Administration	1,789,672	33
	B. Capital Expense		
34	Ownership	151,353	34
	C. Ancillary Expense		
35	Special Cost Centers	2,153,658	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,891,997	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,005,649	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,005,649	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,080	$ 67,321	$ 32.37	1
2	Assistant Director of Nursing	4,655	5,015	141,387	28.19	2
3	Registered Nurses	19,939	21,037	474,109	22.54	3
4	Licensed Practical Nurses	21,167	23,098	441,541	19.12	4
5	CNAs & Orderlies	94,402	102,732	1,217,716	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,920	4,364	55,474	12.71	8
9	Activity Director	2,337	2,720	38,015	13.98	9
10	Activity Assistants	9,014	9,988	94,304	9.44	10
11	Social Service Workers	4,765	4,971	87,536	17.61	11
12	Dietician					12
13	Food Service Supervisor	1,810	1,981	23,358	11.79	13
14	Head Cook	3,859	4,169	45,990	11.03	14
15	Cook Helpers/Assistants	22,514	24,109	213,358	8.85	15
16	Dishwashers					16
17	Maintenance Workers	6,002	6,590	121,802	18.48	17
18	Housekeepers	13,096	13,845	129,844	9.38	18
19	Laundry	7,991	8,751	80,263	9.17	19
20	Administrator	1,788	2,080	94,341	45.36	20
21	Assistant Administrator	1,948	2,176	81,141	37.29	21
22	Other Administrative					22
23	Office Manager	1,900	2,080	40,767	19.60	23
24	Clerical	8,236	8,355	143,848	17.22	24
25	Vocational Instruction	1,623	1,872	54,581	29.16	25
26	Academic Instruction	1,858	2,080	60,116	28.90	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,331	3,757	58,872	15.67	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,623	10,663	117,207	10.99	31
32	Other Health Care(specify)					32
33	Other(specify)	15,321	16,613	309,305	18.62	33
34	TOTAL (lines 1 - 33)	263,083	285,126	$ 4,192,196 *	$ 14.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		6,150	9--3	36
37	Medical Records Consultant		1,200	10--3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 7,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	272	5,278	10--3	52
53	TOTAL (lines 50 - 52)	272	$ 5,278		53

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Kelley	Administrator		$ 94,341
Michael Kaiser	Asst Admin/CFO		81,141
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 175,482

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Clifton Gunderson	Accounting/Auditing	15,550
Bush, Snyder	Legal	1,725
Heyl, Royster	Legal	1,183
Heinold Banwart	Management Svc	1,350
HCIS-Medi Bill	Part B billing	4,871
SIA Inc	Part B billing	1,860
KPMG LLP	Medicare Cons	475
Frost Ruttenberg Rothblatt	Medicare Cons	4,987
Principle Financial Group	Pension Adm	14,425
Personnel Planners	U/C Adm	1,785
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 48,211

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,966
Unemployment Compensation Insurance	7,253
FICA Taxes	304,618
Employee Health Insurance	375,415
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Disability	6,497
Employee Relations	8,899
Life Ins	2,190
Pension	206,918
Health Services	9,199
Tuition Reimbursement	9,088
Hiring and Training	1,351
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,072,394

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,506
Health Care Worker Background Check	
(Indicate # of checks performed 69)	690
Promotion	11,438
Dues and Subscriptions	9,458
Licenses and Fees	526
Less: Public Relations Expense	(11,438)
Non-allowable advertising	
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,180

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,555
Seminar Expense	11,321
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,876

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Replace compressor in dir	6/02	$ 4,500	3	$ 875	$ 1,500	$ 1,500	$ 625	$	$	$	$	$
2	Replace compressor in El	8/02	1,392	3	193	464	464	271					
3	Replace heat exchanger	3/03	2,250	3		750	750	750					
4	New flooring in 216, 115	12/03	1,062	3		177	354	354	177				
5	Replace compressorin sta	8/03	1,389	3		232	463	463	231				
6	Replace gas valves on boil	9/03	1,286	3		214	429	429	214				
7	Repair rooftop a/c unit	7/04	1,049	3			175	350	350	174			
8	Repair dishwasher	2/05	1,989	3				663	663	663			
9	Repair kitchen furnace	3/05	2,538	3				846	846	846			
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,455		$ 1,068	$ 3,337	$ 4,135	$ 4,751	$ 2,481	$ 1,683	$	$	$

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1-1-2005 Ending: 12-31-2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life services Network, 6186**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,496** Line **10--2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,312** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,312**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **No record**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Clifton Gunderson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **They have not released it yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Legal fees are adjusted out**
Attach invoices and a summary of services for all architect and appraisal fees.

DETAIL TO SCHEDULE XVII, LINE 28

Parkside management fee	27600
Misc Income	22249
Social Activities Income	2238
Personal Supplies Income	2651
Sunshine Cart Income	805
Total	55543

Reconcile Schedule V, line 39 to schedule XIV, line 14

Statement to XV, Balance Sheet Apostolic Christian Restmor, #23952

The Corporate Restructuring Initiative began in 2004 was aborted in 2005. The assets that were shown as being transferred over to the Foundation as of 12-31-04 are now shown as back in the facility corporation. Accordingly, there are not two corporations, just the facility corporation, as had been the case in the past.